STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415099	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crystal Lake Rehabilitation and Care Center	999 South Main Street Pascoag, RI 02859

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46539 Based on surveyor observation, record review, resident and staff interview, it has been determined that the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice for 1 of 2 new admissions reviewed, Resident ID #4. Findings are as follows: 1. Record review revealed that Resident ID #4 was admitted to the facility in March of 2024 with diagnoses including, but not limited to, cytomegaloviral disease (CMV- which is a virus that can infect almost anyone, but if you have a weakened immune system, CMV can be serious or even fatal) and kidney transplant status. Review of the hospital discharge document titled After Visit Summary dated 3/20/2024 revealed the following medication orders for the facility: -Valganciclovir (antiviral for CMV) 450 milligram (mg) tablet, take 2 tablets by mouth for a total of 900 mg twice daily. -Gabapentin (used for neuropathy) 300 mg capsule, take 1 capsule by mouth at bedtime. With special instruction which states in part, Another medication with the same name was removed. Continue taking this medication and follow the directions you see here. -Magnesium oxide (a supplement to treat low magnesium) 400 mg tablet, take 1 table by mouth with lunch. -Tamsulosin (used for enlarged prostate) 0.4 mg capsule, take 2 capsules to equal 0.8 mg by mouth daily. Review of the physician orders revealed that the resident was ordered for the following medications: - Gabapentin capsule 100 mg, administer 1 capsule twice a day with a start date of 3/20/2024 - Gabapentin capsule 300 mg, administer 1 capsule at bedtime with a start date of 3/20/2024 - Tamsulosin 0.4 mg capsule administer 1 capsule daily with a start date of 3/20/2024 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review failed to reveal evidence that the Gabapentin and Tamsulosin were transcribed accurately, therefore the resident received the incorrect dosages of these medications for 7 days. Further record review failed to reveal evidence that the Magnesium oxide and Valganciclovir were ordered by the provider, therefore the resident did not receive these ordered meds for 7 days. During a surveyor interview with the resident's physician on 3/28/2024 at 1:32 PM, she acknowledged that the admitting nurse transcribed the medications from a January 2024 hospitalization into the resident's medical record, rather than his/her updated medication orders from his/her March 2024 hospital discharge After Visit Summary. She further revealed that when she was discussing medications with a nurse, she remembered the nurse saying that the list of medications that she reviewed were from January and would expect the nurse to utilize the most recent medication list. Additionally she revealed that she would have expected the resident to receive the medications according to the most recent medication list from the hospital. During a surveyor interview on 3/28/2024 at 1:53 PM with the Director of Nursing Services, she acknowledged that the medications from the After Visit Summary dated 3/20/2024 were not accurately transcribed into the resident's orders. 2. According to the American Nephrology Nurses Association, 2023, Arteriovenous Fistula .(AV fistula, arteriovenous fistula is when an artery and a vein are surgically connect for dialysis treatments) care will help maintain the patency of the vascular access. Measures can be taken to prevent clotting or infection to the access. Patency is assessed by feeling the 'thrill' or vibration of blood through the access or using a stethoscope to listen to the 'bruit' or 'whoosh' of blood through the access. Staff should monitor for signs of infection including pain, tenderness, drainage, swelling, or redness. Review of the hospital discharge document titled After Visit Summary dated 3/20/2024 revealed the resident has an AV fistula and a double lumen power port (a device which is inserted into the chest wall to allow the infusion of medications). Record review failed to reveal evidence that the facility monitored the AV fistula for patency, signs of infection including pain, tenderness, drainage, swelling, or redness. Further record review failed to reveal evidence that the facility was assessing or monitoring the resident's double lumen power port. During a surveyor interview with the resident's physician on 3/28/2024 at 1:32 PM, she revealed that she would expect that the facility would monitor the AV fistula and the double lumen power port. During a surveyor interview on 3/28/2024 at 1:53 PM with the Director of Nursing Services, she acknowledged that the facility was not monitoring the resident's AV fistula or double lumen power port. Furthermore, she revealed that she would expect the facility to monitor the AV fistula and double lumen power port.